Keep enjoying your **VSP® Vision Care** benefits.

Vision care for life

Open Enrollment Dates

September 13 - October 8, 2010
Coverage Begins January 1, 2011

As a current member, you don't have to do anything to keep your VSP Coverage. You'll automatically be re-enrolled and continue to enjoy the benefits you've come to love.

Want to make a change to your coverage?

Choose one of these convenient options:

1. **Online:** Visit VSP at **vsp.com/go/stateofca** and complete the online enrollment form.
2. **Phone:** Call VSP at **800.877.7195** and speak with a member services representative, Monday – Friday, 5:00 a.m. – 7:00 p.m. Pacific Time.
3. **Mail:** Complete and mail the enclosed VSP Change Form in the enclosed envelope.

Choose the coverage that's best for you.

	Monthly
Member Only	$7.53
Member + One	$14.62
Member + Family	$15.73

Value and Savings

VSP benefits are affordable and offer great savings. See how much you can save with VSP:

	Without VSP*	With VSP
Eye Exam	$134	$10
Frame	$75	$25
Single-vision Lenses	$83	
Anti-reflective Coating	$106	$106
Transitions® Lenses	$98	$0
Member-only Annual Contribution	N/A	$106
Total	**$496**	**$247**

*Comparison based on national averages for comprehensive eye exams and most commonly purchased brands.

Average Annual Savings
$249
with a VSP Doctor

New for 2011!

For 2011, dependent children may be covered up to age 26.

Change Form for The State of California

VSP Vision care for life

Need to update your contact information?

Please check your contact information above and note changes here:

_____

_____

_____

Do you have an e-mail address and phone number?

Please provide your e-mail address and phone number to receive an enrollment confirmation.

E-mail Address _____

Phone # _____

Your VSP Coverage

Choose one:

❑ Member Only ❑ Member + Family

❑ Member + One

❑ Cancel My Coverage

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Choose one of these options:

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2. Phone: Call VSP at **800.877.7195**.

3. Mail: Complete and mail this change form.

Contact us. **vsp.com** | **800.877.7195**

	Monthly
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Member + One	$14.62
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Family Member Name (Only list dependents if you did not select "Member Only.")	**Date of Birth** (Month/Day/Year)	**Gender** (Male/Female)	**Relationship to Enrollee** (Spouse/Domestic Partner, Student, Child, etc.)	**Add/Remove**

Please read before signing. By accepting the enrollment terms, I agree that all information is true and accurate. I understand that I am enrolling in this voluntary plan for a twelve (12) month period, unless there is an approved qualifying event. I understand my VSP plan will automatically renew unless I specifically elect not to renew. I authorize VSP to deduct my premiums from my payroll/pension check, and uncollected premiums for two consecutive months will result in the termination of my plan.

Member Signature _____ **Date** _____

JOB#4592CM 8/10 T-F